SOLIRIS REFERRAL FORM	SUPERIOR BIOLOGICS Fax Referral To: 914-747-1170 Phone: 855-747-1150	
Date: ____________________________		

Needs by Date: __________________ Ship to ☐ Patient's Home ☐ Prescriber 1st Order Only ☐ Prescriber All Orders

PATIENT INFORMATION

Patient Name: ____________________________________
Address: ____________________________________
City, State, Zip: ____________________________________
Home Phone: ____________________________________
Cell Phone: ____________________________________
Date of Birth: ______________ Gender: ☐ M ☐ F

PRESCRIBER INFORMATION

Prescriber Name: ____________________________________
Address: ____________________________________
City, State, Zip: ____________________________________
Phone: ___________________ Fax: ___________________
DEA#: ___________________ NPI#: ___________________
Contact Person: ____________________________________

INSURANCE INFORMATION *(Please attach the front and back of insurance and prescription drug card)*

Primary Insurance: _________________________________ ID#: __________________________ Group: ______________
Secondary Insurance: _________________________________ ID#: __________________________ Group: ______________
Prescription Card: _____________ ID#: ________________ BIN: ____________ PCN: _________ Group: ______________

DIAGNOSIS & CLINICAL ASSESSMENT *(Fill in below or attach lab work)*

☐ New to Therapy ☐ Currently on Therapy ☐ Date of Last IVIG Infusion: ___________ ☐ IVIG Dosing Regimen: ___________________

Diagnosis: ☐ G70.00 Myasthenia Gravis without (acute) exacerbation ☐ G70.01 Myasthenia Gravis with (acute) exacerbation ☐ in crisis

☐ D59.3 atypical Hemolytic Uremic Syndrome (aHUS) **Date of Diagnosis**: ___________ **Current Weight**: __________ **Date**: _________

Allergies: _________________________ **Date of Meningococcal Vaccination**: ____________

Previously on PLEX treatment ☐ Yes ☐ No **Date of last treatment**: ___________ **Is patient AchR antibody positive?** ☐ Yes ☐ No

Notes / Comments: ____

Soliris® (eculizumab)

Dose / Strength	Directions	Quantity	Refills
☐ Injection: 300mg / 30mL (10mg/mL) in single-dose vial (3)	☐ **For treatment of Myasthenia Gravis:**		
	☐ 900mg weekly for the first 4 weeks, followed by	☐ 4-week supply	☐ 1-year supply
	☐ 1200mg for the fifth dose 1 week later, then	☐ 4-week supply ☐ 12-week supply ☐ Other	
	☐ 1200mg every 2 weeks thereafter.	☐ 4-week supply ☐ 12-week supply ☐ Other	
	☐ **For treatment of aHUS – 18 years or older:**		☐ 1-year supply
	☐ 900mg weekly for the first 4 weeks, followed by	☐ 4-week supply	
	☐ 1200mg for the fifth dose 1 week later, then	☐ 4-week supply ☐ 12-week supply ☐ Other	
	☐ 1200mg every 2 weeks thereafter.	☐ 4-week supply ☐ 12-week supply ☐ Other	
	☐ **Other:**		☐ ________
	☐ ________________________________	☐ _____________	
	☐ ________________________________	☐ _____________	

Other/Notes:____
____

Prescriber Signature: ____________________________ **DAW (Dispense as Written)** ☐ Y ☐ N **Date:** __________

If Hometech Advanced Therapies is the patient's choice, please Call-in, Fax, or Mail prescriptions to:
Hometech Advanced Therapies, 505 Elmwood Avenue, Sharon Hill, PA 19079 • Phone (855) 494-3121, Fax (855) 884-9283